Texas Department of Insurance
Division of Workers' Compensation
Medical Fee Dispute Resolution, MS-48
7551 Metro Center Drive, Suite 100 • Austin, Texas 78744-1645
512-804-4000 telephone • 512-804-4811 fax • www.tdi.texas.gov

MEDICAL FEE DISPUTE RESOLUTION FINDINGS AND DECISION

GENERAL INFORMATION

Requestor Name and Address

HOUSTON ORTHOPEDIC & SPINE HOSPITAL
5420 WEST LOOP SOUTH 3600
BELLAIRE TX 77401

Respondent Name
TEXAS MUTUAL INSURANCE CO

Carrier's Austin Representative Box
Box Number 54

MFDR Tracking Number
M4-12-2391-01

MFDR Date Received
MARCH 19, 2012

REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary: "Auth 9119391 pt health prohibited surgery. Pt came back 11/6/11 but lab's services was provided."

Amount in Dispute: $5,243.22

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary: "The requestor admitted the claimant to the hospital on 10/27/11. Upon receipt of the bill Texas Mutual reviewed its claim file for a preauthorization of the procedure. None was found because there was no record of it being requested. The requestor states in its DWC-60 packet the services provided 10/27/11 – 10/29/11 were lab services provided in association for preauthorization number 9119391…Texas Mutual has no argument with the provision of lab services in anticipation of an authorized surgery. However, the preauthorization number cited by the requestor is for the surgery proper. The issue in this dispute is that the requestor fails to provide a reason for a two day inpatient admission for lab work. Absent such, the admission requires preauthorization, which was not obtained."

Response Submitted by: Texas Mutual Insurance Co.

SUMMARY OF FINDINGS

Dates of Service	Disputed Services	Amount In Dispute	Amount Due
October 27, 2011	Inpatient Hospital Services	$5,243.22	$0.00

FINDINGS AND DECISION

This medical fee dispute is decided pursuant to Texas Labor Code §413.031 and all applicable, adopted rules of the Texas Department of Insurance, Division of Workers' Compensation.

Background

1. 28 Texas Administrative Code §133.307 sets out the procedures for resolving a medical fee dispute.
2. 28 Texas Administrative Code §134.600, requires preauthorization for specific treatments and services.
3. The services in dispute were reduced/denied by the respondent with the following reason codes:

   Explanation of benefits CAC-197-Precertification/Authorization/Notification absent.

- CAC-197-Precertification/Authorization/Notification absent.
- 240-Preauthorization not obtained.
- Need operation report for this date of service.
- CAC-16-Claim/service lacks information which is needed for adjudication. At least one remark code must be provided (May be comprised of either the remittance advice remark code or NCPDP reject reason code.)
- 225-The submitted documentation does not support the service being billed. We will re-evaluate this upon receipt of clarifying information.

Issues

1. Does a preauthorization issue exist in this dispute?

Findings

1. The insurance carrier denied reimbursement for the disputed inpatient services, based upon "CAC-197-Precertification/Authorization/Notification absent," and "240-Preauthorization not obtained."

   28 Texas Administrative Code §134.600 (c)(1)(B), states "The carrier is liable for all reasonable and necessary medical costs relating to the health care: (1) listed in subsection (p) or (q) of this section only when the following situations occur:

   (B) preauthorization of any health care listed in subsection (p) of this section that was approved prior to providing the health care."

   28 Texas Administrative Code §134.600(p)(1) states "Non-emergency health care requiring preauthorization includes: (1) inpatient hospital admissions, including the principal scheduled procedure(s) and the length of stay."

   On May 19, 2011, the respondent gave preauthorization for the following: "Per Physician Advisor, and per mutual agreement with KANDI, authorization given for the requested services/treatments for: INPT Poster Lumbar fusion w/pedical screws and rods ICBG, anterior lumbar fusion, CCALIF AOI SCREWS L4-S1 WIDE DECOMPRESSION L4-S1 LOS 3 Days, DME: LSO Brace + Bone Stimulator."

   The requestor states in the position summary that "Auth 9119391 pt health prohibited surgery. Pt came back 11/6/11 but lab's services was provided".

   The respondent states in the position summary that "The requestor states in its DWC-60 packet the services provided 10/27/11 – 10/29/11 were lab services provided in association for preauthorization number 9119391…Texas Mutual has no argument with the provision of lab services in anticipation of an authorized surgery. However, the preauthorization number cited by the requestor is for the surgery proper. The issue in this dispute is that the requestor fails to provide a reason for a two day inpatient admission for lab work. Absent such, the admission requires preauthorization, which was not obtained."

   The requestor did not submit a preauthorization report for the two day inpatient stay for lab work; therefore, reimbursement is not recommended.

Conclusion

For the reasons stated above, the Division finds that the requestor has not established that additional reimbursement is due. As a result, the amount ordered is $0.00.

ORDER

Based upon the documentation submitted by the parties and in accordance with the provisions of Texas Labor Code §413.031, the Division has determined that the requestor is entitled to $0.00 reimbursement for the disputed services.

Authorized Signature

		1/29/2013
Signature	Medical Fee Dispute Resolution Officer	Date

YOUR RIGHT TO APPEAL

Either party to this medical fee dispute may appeal this decision by requesting a contested case hearing. A completed **Request for a Medical Contested Case Hearing** (form **DWC045A**) must be received by the DWC Chief Clerk of Proceedings within **twenty** days of your receipt of this decision. A request for hearing should be sent to: Chief Clerk of Proceedings, Texas Department of Insurance, Division of Workers Compensation, P.O. Box 17787, Austin, Texas, 78744. The party seeking review of the MDR decision shall deliver a copy of the request for a hearing to all other parties involved in the dispute at the same time the request is filed with the Division. **Please include a copy of the *Medical Fee Dispute Resolution Findings and Decision*** together with any other required information specified in 28 Texas Administrative Code §148.3(c), including a **certificate of service demonstrating that the request has been sent to the other party**.

Si prefiere hablar con una persona en español acerca de ésta correspondencia, favor de llamar a 512-804-4812.